Premier Behavioral Systems of Tennessee, LLC

For the Period
January 1, 1997, Through June 30, 1998

Arthur A. Hayes, Jr., CPA, JD, CFE
Director

Ronald M. Paolini, CPA
Assistant Director

Clare A. Tucker, CPA
Manager

John R. Mattingly, CPA
In-Charge Auditor

Beth Pugh
Julie Rogers, CPA
Staff Auditors

Amy Brack
Editor

November 5, 1999

The Honorable Don Sundquist, Governor
and
Members of the General Assembly
State Capitol
Nashville, Tennessee 37243
and
The Honorable John Ferguson, Commissioner
Department of Finance and Administration
First Floor, State Capitol
Nashville, Tennessee 37243-0285

Ladies and Gentlemen:

Pursuant to the agreement between the Comptroller of the Treasury and the Department of Finance and Administration, the Division of State Audit performs examinations of behavioral health organizations participating in the Tennessee TennCare Partners Program under Title XIX of the Social Security Act.

Submitted herewith is the report of the examination of Premier Behavioral Systems of Tennessee, LLC, for the period January 1, 1997, through June 30, 1998.

Sincerely,

John G. Morgan
Comptroller of the Treasury

JGM/pn
99/024
cc: Joe Keane
Theresa Clarke-Lindsey
John S. Tighe

State of Tennessee

Audit Highlights

Comptroller of the Treasury Division of State Audit

TennCare Partners Report
Premier Behavioral Systems of Tennessee, LLC,
For the Period January 1, 1997, through June 30, 1998

Findings

Deficiencies in the Claims Processing System
Premier Behavioral Systems of Tennessee, LLC, (Premier) did not fulfill contract reporting requirements and processing efficiency requirements specified by the TennCare Partners contract. Errors were discovered in the payment and denial of mental health and substance abuse claims (page 12).

Deficiencies in the Authorization System
Premier has invalidly denied claims for no prior authorization when a valid authorization exists. Premier's authorization system failed to properly transfer all authorizations to the claims processing subcontractor in a timely manner (page 15).

Deficiencies in Encounter Data Reporting
Premier inadequately reported encounter data required by the contract: the encounter data did not include all revenue, procedure, and diagnosis codes (page 16).

.

Inaccurate Annual and Quarterly Statement Reporting
Equity was understated $1,520,676.52 as of December 31, 1997, due to errors in the annual statement reporting. Equity was overstated $8,656 as of June 30, 1998, due to errors in quarterly statement reporting (page 17).

Incomplete Payment Calculation to Community Mental Health Centers
Premier did not apply all of the compensation terms of their contract with the Community Mental Health Centers (page 19).

Provider Contract Language Deficiencies

Premier did not include in the provider agreements all requirements specified by the TennCare Partners contract (page 20).

"Audit Highlights" is a summary of the report. To obtain the complete report which contains all findings, recommendations, and management comments, please contact

Comptroller of the Treasury, Division of State Audit
1500 James K. Polk Building, Nashville, TN 37243-0264
(615) 741-3697

TennCare Partners Report
Premier Behavioral Systems of Tennessee, LLC
For the Period January 1, 1997, through June 30, 1998

TABLE OF CONTENTS

TennCare Partners Report
Premier Behavioral Systems of Tennessee, LLC
For the Period January 1, 1997, Through June 30, 1998

INTRODUCTION

PURPOSE AND AUTHORITY OF THE EXAMINATION

The terms and conditions for authorizing the TennCare Partners Program, as well as the contracts between the State of Tennessee and the behavioral health organizations (BHOs), require that examinations of the BHOs be conducted by the Tennessee Comptroller's Office. The contract between the Tennessee Department of Finance and Administration and the Comptroller's Office also contains a provision requiring the examinations.

Under their contract with the state, the BHOs have asserted that they are in compliance with stated requirements regarding their provision of services to TennCare Partners participants. The purpose of our examination is to render an opinion on the BHOs' assertions that they have complied with certain financial-related requirements of their contract with the state.

BACKGROUND

The TennCare Partners Program, a managed care capitation program for mental health and substance abuse services, was initiated on July 1, 1996, and is designed to function in a manner similar to the TennCare Program. TennCare replaced the existing Medicaid Program on January 1, 1994, with a program of managed health care providing traditional medical services. Prior to July 1, 1996, mental health and substance abuse services were generally funded by grants or fee-for-service payments from the state. Although some grant payments, such as contracts with the Department of Children's Services, to the community mental health centers are unaffected by the TennCare Partners Program, funding for most of the services has shifted to the TennCare Partners Program. Each month, the state pays a capitation rate for each TennCare Partners Program participant to one of the two managed care organizations, referred to as behavioral health organizations (BHOs), that contract with the state to provide mental health and substance abuse services. The BHOs are Premier Behavioral Systems of Tennessee, LLC, and Tennessee Behavioral Health Inc. (TBH).

TENNCARE PARTNERS PROGRAM PARTICIPANTS

The assignment of TennCare Partners Program participants to the two BHOs is based upon the participants' enrollment in the TennCare managed care organizations. The managed care organizations and their assigned participants to Premier are as follows:

- HealthNet TennCare HMO, Inc.*
- Blue Cross Blue Shield of Tennessee(excluding East Tennessee**)
- Heritage National Healthplan of Tennessee, Inc.
- OmniCare Health Plan, Inc.
- Phoenix Healthcare of Tennessee, Inc.
- Vanderbilt Health Plans, Inc.

*Merged with Phoenix Healthcare of Tennessee, Inc., in December 1997.
**East Tennessee includes the counties Anderson, Blount, Campbell, Claiborne, Cocke, Grainger, Hamblen, Jefferson, Knox, Loudon, Monroe, Morgan, Roane, Scott, Sevier, Union.

The remaining managed care organizations' enrollments are assigned to TBH.

There are two categories of participants in the TennCare Partners Program: priority participants and basic participants. Priority participants include individuals diagnosed as severely and/or persistently mentally ill (SPMI) aged 18 years or older and individuals diagnosed as severe emotional disturbance (SED) under the age of 18. TennCare Partners participants who are not priority participants are referred to as basic participants. Services covered for both the priority and basic participants include inpatient psychiatric hospitalization, outpatient mental health services, substance abuse treatment, psychiatric pharmacy and lab-related services, trans-portation to mental health and substance abuse services, and specialized crisis services. Additional services covered for the priority population include mental health case management, 24-hour residential treatment, housing/residential care, specialized outpatient and symptom management, and psychiatric rehabilitation services.

An additional category of individuals for which mental health and substance abuse services are covered by the BHOs is judicials. These individuals are not considered enrollees or participants in the BHO plan but are entitled to coverage for services required by the statute or court order under which the individual was referred.

RESPONSIBILITIES OF CONTRACTED PARTIES

The Tennessee Department of Mental Health and Mental Retardation (TDMHMR) is the state agency responsible for administration of the TennCare Partners Program. TDMHMR and the Bureau of TennCare are responsible for verifying the eligibility of participants and for assigning them to and disenrolling them from the TennCare Partners Program.

Specific qualifications and responsibilities with which the behavioral health organization must comply include the following:

1. Maintain service accessibility and availability through the existence of a current statewide network of appropriately licensed and credentialed mental health and substance abuse providers capable of providing 24-hour comprehensive mental health and substance abuse care;

2. Pay or appropriately deny 95% of the total number of clean claims from both contract and noncontract providers within 30 calendar days of receipt, pay or appropriately deny the remaining 5% of the total number of clean claims within the next ten days, and process all claims submitted by contract and noncontract providers within 60 calendar days of receipt;

3. Provide mental health case management in accordance with standards set by TDMHMR;

4. Identify persons in need of clinical related group/target population group assessments, provide these assessments promptly and accurately, and follow up identifications with treatment plans and reassessments as necessary;

5. Manage mental health and substance abuse provider networks; recruit, credential, enroll, train, and manage providers; and maintain positive provider relationships;

6. Provide a responsive grievance and appeals process, both formal and informal;

7. Meet and maintain the administrative requirements of the Tennessee Department of Commerce and Insurance (TDCI) as specifically set forth in the provider risk contract or applicable statute;

8. Establish and maintain adequate risk reserves;

9. Have adequate and appropriate general liability, professional liability, and workers compensation insurance for the protection of clients, staff, facilities, and the general public;

10. Measure and report utilization, cost, quality, and patient satisfaction data through a management information system that supports the specific administrative and clinical decision making required for delivery of mental health and substance abuse services; and

11. Mutually agree to such other requirements as may be reasonably established by TennCare, TDCI, and TDMHMR.

Premier is allowed to retain up to 10% of the monthly capitation amount paid by the Bureau of TennCare as a management fee, with the remainder of the monthly capitation payment available for the payment of covered direct mental health and substance abuse services and premium taxes. Any and all excess administrative costs are borne by Premier. If the actual accrued amount paid by Premier for covered services and premium tax is less than 90% of the amounts paid by the Bureau of TennCare, then Premier shall remit to TDMHMR 100% of the difference.

ADMINISTRATIVE ORGANIZATION OF PREMIER

Premier Behavioral Systems of Tennessee, LLC, was established in May 1996 for the purpose of delivering mental health services under the TennCare Partners Program. The current members include Premier Holdings, Inc. (PH), and Columbia Behavioral Health of Tennessee, LLC (CBHT). PH is a wholly-owned subsidiary of Magellan Health Services, Inc., and CBHT is jointly owned by Columbia/HCA and First Health Corporation. Magellan Health Services, Inc., is a majority owner of Advocare of Tennessee, Inc. (Advocare). Premier contracts with the related parties to provide specific administrative and mental health and substance abuse services through service agreements. Advocare is to provide general administrative services as well as care services for basic and priority outpatient, case management, and grant and crisis payments. Administrative services are paid to Advocare on per member per month (PMPM) fixed amount. Payments for care services to Advocare are based upon negotiated payments with Community Mental Health Centers (CMHCs) or other providers with no risk assumption by Advocare. Until July 1, 1997, CBHT was to provide care services for inpatient, intensive outpatient, partial hospitalization, and regional mental health institutes. CBHT was paid through June 30, 1997, a PMPM capitation by Premier with risk or benefit depending on whether actual cost of care remains within 3 percent of the actual PMPM amounts paid to CBHT. After June 30, 1997, CBHT provides only the hospital network with no risk assumption for mental health inpatient services and is paid a significantly lower PMPM capitation. Premier contracted with FHC Options, Inc., a 50 percent owner of Columbia Behavioral Health of Tennessee, LLC, to provide claims processing services through January 1998. After January 1998, PBST contracted with Green Springs Health Services, Inc. (GSHS), to provide claims processing services. GSHS is the parent of Advocare.

The officers and board of directors for Premier as of December 31, 1997, are as follows:

Officers for Premier

Charles D. Klusener, Chief Manager
Mary Francis Rutledge, Secretary

Board of Directors for Premier

Henry Harbin, M.D.	Robert Osburn
Charles Kanach	John Wider
Sandy Butters	Sam Moody

PROVIDER CONTRACTS AND SUBCONTRACTS

Premier must obtain written approval from TDMHMR for all of its provider contracts and subcontracts. The contract between TDMHMR and Premier requires that Premier contract with the State of Tennessee's five regional mental health institutes. These institutes provide essential inpatient mental health services to the priority population. Premier has contracted with the regional mental health institutes on a per diem basis. Inpatient, intensive outpatient, and partial hospitalization services are also provided by hospitals across Tennessee on a per diem basis.

In addition, the contract encourages Premier to contract with community mental health centers (CMHCs). The primary providers of outpatient mental health services for the priority population are the CMHCs located across the state. Premier originally contracted with 29 CMHCs to provide medically/psychologically necessary designated covered services. The CMHCs act as care coordinators responsible for arranging the behavioral health care needs of their assigned participants. All of the centers except three have a contractual arrangement with Premier which specifies a certain per priority member per month rate to be used in the calculation of the monthly priority case rate paid to those centers. Premier calculates the monthly case rate for each of these centers by multiplying the number of priority participants reported by a center by the specified per member per month rate, then dividing that number by the total priority cases reported for all centers. The other three centers' contractual arrangements specify a fixed case rate. The assignment of the priority population to the CMHCs at the effective date of the contracts, July 1, 1996, is based on a comparison between the CMHC's enrollment records with MCO or BHO enrollment data. Assignment of newly assigned priority members will be determined by member's choice. If the assigned members elect to receive services from other providers, then the CMHC's monthly case rate payments will be reduced on a percentage basis according to the services received. Other providers include physicians, psychiatrists, licensed social workers, and hospitals and are paid based upon a fee schedule for the procedures provided. Each CMHC also receives grant payments at the same funding levels for the prior fiscal year based on Premier's percentage of total TennCare Partners enrollment. Grants represent payments for non-clinical adult services, psychosocial services, and crisis teams provided by the CMHCs. In addition to the case rate payments, the CMHCs are eligible to receive additional compensation based on the amount of inpatient savings that is realized for the priority population that the CMHC serves.

Five TennCare managed care organizations (MCOs) have been contracted and paid by Premier a subcapitation based upon number of members enrolled in the MCOs. The MCOs have contracted with primary care physicians who provide a portion of the mental health services for Premier. Also, the MCOs provide some of the lab, transportation, and pharmacy services that are

the responsibility of Premier. Additionally, Premier has contracted with Quality Transportation, Inc., to provide transportation services. PCS Health Systems, Inc., was contracted to provide pharmacy services January through October 1997, and then contracted with ProMark for the remainder of the audit period.

ANNUAL AND QUARTERLY STATEMENT REPORTING

As a BHO, Premier Behavioral Systems of Tennessee, LLC (Premier), files annual and quarterly statements with the Tennessee Department of Commerce and Insurance. The department uses the information filed on these reports to determine if the behavioral health organization meets the minimum requirements for statutory reserves. The statements are filed on a statutory basis of accounting. Statutory accounting differs from generally accepted accounting principles because "admitted" assets must be easily converted to cash to pay for outstanding claims. "Non-admitted" assets such as furniture, equipment, and prepaid expenses are not to be included in the determination of plan assets and should be reduced from equity.

As of December 31, 1997, Premier reported $41,934,796 in admitted assets, $36,572,829 in liabilities, and $5,361,967 in equity on its annual statement. Premier reported total revenues of $192,407,954 and total expenses of $196,110,749 producing a net loss of $3,702,796 for the period January 1 through December 31, 1997. Revenue comprises $191,281,564 in capitation fee payments from TennCare and $1,126,390 in investment income. The plan reported $178,113,315 in mental health and substance abuse services and $17,997,434 in administrative expenses. Premium taxes paid to the State were reported as $3,304,482. Mental health and substance abuse services represents 93.1% of capitation fee payments from TennCare, and administrative expenses less premium taxes represents 7.7% of capitation fee payments from TennCare. Premier reported a restricted deposit of $1,203,310 to satisfy requirements of the TennCare Partners Program contract.

As of June 30, 1998, Premier reported $41,096,771 in admitted assets, $31,374,390 in liabilities, and $9,724,381 in equity on its quarterly statement. Premier reported total revenues of $106,275,371 and total expenses of $102,016,831 producing a net income of $4,258,540 for the period January 1 through June 30, 1998. Revenue comprises $105,494,204 in capitation fee payments from TennCare and $781,167 in investment income. The plan reported $91,939,477 in mental health and substance abuse services and $10,077,355 in administrative expenses. Premium taxes paid to the State were reported as $1,704,356. Mental health and substance abuse services represents 87.2% of capitation fee payments from TennCare and administrative expenses less premium taxes represents 7.9% of capitation fee payments from TennCare. Premier reported a restricted deposit of $2,203,310 to satisfy requirements of the TennCare Partners Program contract.

SCOPE OF THE EXAMINATION

Our examination covers certain financial-related requirements of the contract between the state and Premier for the period January 1, 1997, through June 30, 1998. The requirements covered are referred to under management's assertions specified later in the Independent Accountants' report. Our examination does not cover those portions of the contract concerning quality of care, clinical, and medical requirements.

PRIOR FINDINGS

The previous review of Premier Behavioral Systems of Tennessee, LLC (Premier), for the period July 1 through December 31, 1996, included the following findings:

1. **Failure to maintain minimum equity requirements and positive working capital**
   Premier failed to meet minimum equity and working capital requirements. As of December 31, 1996, Premier had a review-adjusted equity of ($2,216,828).

2. **Incorrect payment calculations to community mental health centers**
   Premier did not correctly apply all of the compensation terms of their contract with the Community Mental Health Centers (CMHCs). Case management expense was understated $640,070 because Premier's statewide enrollment for priority participants was not adjusted as of December 31, 1996. Consequently, the enrollment for priority participants for each CMHC had not been adjusted.

3. **Inaccurate annual statement reporting**
   Net income was overstated $46,559 and total liabilities were understated $51,040 on the annual statement reporting for the period July 1 through December 31, 1996.

4. **Judicial claims denied**
   Premier inappropriately denied court-ordered services for individuals who were not participants in the TennCare Partners Program.

5. **Deficiencies in the authorization system**
   Premier has invalidly denied claims for "no authorization" when a valid authorization exists. Premier's authorization system failed to properly transfer all authorizations to the claims processing subcontractors.

6. **Deficiencies in claims processing**
   Premier did not fulfill contract reporting and processing efficiency requirements. Errors were discovered in the payment and denial of mental health and substance abuse claims. Remittance advices did not adequately communicate all denial reasons in order for providers to respond.

7. **Deficiencies in encounter data reporting**
   Premier inadequately reported encounter data required by contract: the encounter data did not include all revenue, procedure, and diagnosis codes.

8. **Excessive rates paid to affiliated providers**
   Rates paid to providers affiliated with Premier were higher than the rates paid to non-affiliated providers, in violation of the TennCare Partners Program contract.

Findings 1, 4, and 8 have been satisfactorily remedied. Findings 2, 3, 5, 6, and 7 will be repeated in the current report (see the Findings and Recommendations section of this report).

SUBSEQUENT EVENTS

Subsequent material events and correction of errors discovered by the Division of State Audit will affect the annual statement reporting for the year ended December 31, 1997, and the quarterly statement reporting for the period January 1 through June 30, 1998. The following adjustments were made by the Division of State Audit to reported equity at December 31, 1997:

- Accounts receivable related to pharmacy recoupments from managed care organizations were overstated $207,775.

- Accounts payable for pharmacy expenses were understated $159,848.

- Premium tax payable was understated $69,173.

- Capitations fee payments from TennCare of $1,560,794 were incorrectly recorded as deferred revenue.

- The settlement receivable with the State of Tennessee for payments to the regional mental health institutes ultimately was $396,679 greater than estimated.

The effect of these adjustments will increase reported equity from $5,361,967 to $6,882,644 as of December 31, 1997. Premier's minimum net worth requirement at December 31, 1997, was $4,563,831 per the TennCare Partners contract Section 3.3.2.1.

The following adjustments were made by the Division of State Audit to reported equity at June 30, 1998:

- Accounts receivable related to pharmacy recoupments from managed care organizations were overstated $592,526.

- Accounts payable for pharmacy expenses were understated $981,647.

- Premium tax payable was understated $50,261.

- Capitations fee payments from TennCare were overstated $715,138.

- Interest receivable was understated $2,556.

- The settlement payable with the Community Mental Health Centers (CMHCs) ultimately was $2,328,721 less than estimated.

- Because of deficiencies of case management reporting by CMHCs, the Bureau of TennCare permanently retained the 10% withholds from capitation payments for January and February 1998, totalling $3,204,831. In August and September 1998, Premier recouped this amount from the capitation payments it makes to the CMHCs. The effect of these events is to decrease premiums earned and CMHC capitation expense by $3,204,831, resulting in no effect to equity.

The effect of these adjustments will decrease reported equity from $9,724,381 to $9,715,725 as of June 30, 1998. Premier's minimum net worth requirement at June 30, 1998, was $8,738,447 per the TennCare Partners contract Section 3.3.2.1.

Independent Accountants' Report

November 18, 1998

The Honorable Don Sundquist, Governor
and
Members of the General Assembly
State Capitol
Nashville, Tennessee 37243
and
The Honorable John Ferguson, Commissioner
Department of Finance and Administration
First Floor, State Capitol
Nashville, Tennessee 37243-0285

Ladies and Gentlemen:

We have examined management's assertions, included in its representation letter dated November 19, 1998, that Premier Behavioral Systems of Tennessee, LLC, complied with the following requirements during the year ended December 31, 1997, and for the period June 1 through June 30, 1998.

- The organization is in compliance with the minimum equity requirements as specified in the contract with the state.

- The organization has complied with its contractual duty to provide certain member services to its participants such as membership cards, provider directories, and documentation and resolution of complaints and appeals.

As discussed in management's representation letter, management is responsible for ensuring compliance with those requirements. Our responsibility is to express an opinion on management's assertions about the organization's compliance based on our examination.

Our examination was made in accordance with standards established by the American Institute of Certified Public Accountants and, accordingly, included examining, on a test basis, evidence about Premier's compliance with those requirements and performing such other procedures as we considered necessary under the circumstances. We believe that our examination provides a reasonable basis for our opinion. Our examination does not provide a legal determination on Premier's compliance with specified requirements.

Our examination disclosed the following material noncompliance applicable to Premier:

- The organization did not comply with contractual claims processing requirements.
- The organization did not comply with contractual reporting requirements.
- The organization did not comply with contractual requirements concerning its agreements with subcontractors and providers.
- The organization did not properly file the quarterly and annual statements with the state according to National Association of Insurance Commissioners (NAIC) guidelines.

In our opinion, except for the material noncompliance described above, management's assertions that Premier Behavioral Systems of Tennessee, LLC, complied with the aforementioned requirements for the year ended December 31, 1997, and for the period January 1 through June 30, 1998, are fairly stated, in all material respects.

This report is intended solely for the use of the Tennessee General Assembly and the Tennessee Department of Health. However, this report is a matter of public record and its distribution is not limited.

Sincerely,

Arthur A. Hayes, Jr., CPA, Director
Division of State Audit

AAH/pn

FINDINGS AND RECOMMENDATIONS

1. Deficiencies in the claims processing system

Finding

Premier Behavioral Systems of Tennessee, LLC (Premier), has not fulfilled contract reporting and efficiency requirements. Ninety claims selected for testing for mental health and substance abuse services provided from January 1, 1997, through June 30, 1998, revealed the following:

a. The following deficiencies were discovered for 26 claims by the subcontractor, Options, for dates of service January 1, 1997, through January 30, 1998:

- Two claims were improperly denied. One claim was denied because the provider had not obtained a prior authorization. Premier's authorization system confirmed a prior authorization had been granted. One claim was denied because the dates of service were outside the member's effective dates of coverage. The dates of service were in the member's effective dates of coverage per TennCare's eligibility system.

- Two claims were incorrectly paid. One claim incorrectly applied a 10% withhold to a noncontracted provider's payment. The payment for one claim did not agree with the provider's fee schedule.

- Copies of 3 of the 26 claims provided by Options were ileligible. We were not able to ascertain compliance with contract reporting requirements.

- For 5 of the 26 claims processed by Options, the claim identification number which indicates the date of receipt was not stamped on 5 of the 26 claims. Also for one claim, the claim identification number indicated that the received date was 10 days after the received date recorded in the claims processing system. The date stamping of claims on the date of receipt is essential in properly processing the claim and computing the processing lag for the measure of processing efficiency and external reporting.

b. The following processing and payment errors were discovered for 54 claims processed by the subcontractor, Green Springs Health Services, Inc. (GSHS), for dates of service February 1, 1998, through June 30, 1998:

- Four claims were paid incorrectly:
    - Three claims applied a ten% withhold to payments to non contracted providers.
    - For one claim, one day of a seven-day inpatient visit was denied for no prior authorization. An authorization for seven days of service existed, but only six days were accepted and paid.
- The denial of four claims was improper:
    - One claim for a court-ordered emergency admission was denied because the hospital had not obtained a prior authorization. Premier is required to pay at least the first 72 hours without a requirement for an authorization per Section 2.6.5.1.1.1 of the TennCare Partners contract.
    - For one claim, the Tennessee Department of Health (TDH) overturned an appeal related to a claim previously by Premier. No authorization was recorded in Premier's authorization system for the overturned appeal, resulting in an improper denial on the subsequent submission.
    - One claim for emergency transportation provided by a county ambulance service was denied with the explanation that the service falls within capitated services. Premier is required to furnish emergency transportation services for enrollees. Under TCA 33-6-111, a third-party contractor (or the county) is not expressly prohibited from seeking reimbursement for emergency transportation from the insurer of the person being transported. Applying this reason for denial is inaccurate because Premier does not make capitation payment to the county ambulance service.
    - One claim for a child in state custody was denied with the explanation that the service falls with capitated services. The claim should have paid fee for service.

c. The remaining ten claims selected for testing were submitted to Premier electronically for dates of service January 1, 1997, through June 30, 1998. Six claims were submitted by CMHCs, one claim was submitted by the transportation subcontractor, and three claims were submitted by the pharmacy subcontractor. The following deficiencies were revealed:

- Two pharmacy claims paid fee for service. Premier was unable to provide a fee schedule. Premier does not verify or have the ability to confirm if the pharmacy subcontractor has paid the correct amounts.

- One pharmacy claim was denied. Premier was unable to provide an explanation for the denial. Premier does not verify or have the ability to confirm if the pharmacy subcontractor has appropriately denied claims.

d. Premier has not met claims processing requirements specified by the TennCare Partners contract. Claims submitted by providers for mental health and substance abuse services were not always processed within the 60-day requirement. Also, Premier did not pay or deny 95% of the clean claims tested within the 30-day requirement with the remaining 5% of the clean claims to be paid or denied within ten calendar days. Of the 90 claims, all 90 were clean claims with the following lags:

- 71 claims within 30 days (78.89%)
- 6 claims within 31 to 40 days (6.67%)
- 10 claims within 41 to 60 days (11.11%)
- 3 claims over 60 days (3.33%)

Section 3.13.2 of the TennCare Partners contract with Premier states,

> The CONTRACTOR shall pay or appropriately deny within thirty (30) calendar days of receipt ninety five percent (95%) of all clean claims submitted by contract and non-contract providers . . . . Thereafter, the CONTRACTOR shall pay the remaining five percent (5%) of clean claims within ten (10) calendar days. The CONTRACTOR shall also process within sixty (60) calendar days of receipt all claims submitted by contract and non-contract providers.

Because of the inaccuracies and inefficiencies of the claims processing system, Premier has not fulfilled claims processing requirements of the TennCare Partners contract. The errors and delays in claims processing have jeopardized the stability of the TennCare Partners Program. Mental health and substance abuse providers have experienced significant financial and administrative problems caused by Premier's inability to process claims correctly.

Recommendation

Premier should adhere to contract reporting requirements and processing efficiency requirements for claims processing. Claims should not be denied for no prior authorization when the provider has obtained an authorization. Premier should not deny claims for eligibility when the dates of service are within the member's effective dates of coverage. Court-ordered emergency admission should not be denied for no prior authorization. Claims for children in state custody should be paid fee-for-service. Emergency transportation claims should not be denied as covered under capitated services. Claims should be paid according to the correct fee schedule. Noncontracted providers should not be subject to withholds. Claims should be date-stamped on the date of receipt. Premier should have the ability to verify if the pharmacy subcontractor is correctly paying or denying claims.

Management's Comment

We agree with this finding.

2. Deficiencies in the authorization system

Finding

Premier improperly denied claims because the provider had not obtained prior authorization for the service. From the 90 claims selected for testing, the following was revealed:

- For one claim, the authorization system confirmed a prior authorization had been granted. During 1997, authorizations were not properly transferred adequately and in a timely manner from the authorization system to the claims processing subcontractor. As a result, claims were improperly denied because they were received and processed before Premier communicated the authorizations to the claims processing subcontractor.

- For one claim, one day of a seven-day inpatient visit was denied for no prior authorization. An authorization for seven days of service existed, but only six days were accepted and paid.

- For one claim, the Tennessee Department of Health (TDH) overturned an appeal related to a claim previously denied by Premier. No authorization was recorded in Premier's authorization system for the overturned appeal, resulting in an improper denial on the subsequent submission.

Recommendation

Premier should not deny claims for no prior authorization when a valid authorization exists. Authorizations should be made available to Premier's claims processing subcontractors in a timely manner. An authorization should be recorded for overturned appeals by TDH.

Management's Comment

Since February 1, 1998, Magellan Behavioral Health has processed claims for Premier Behavioral Health. While we still transmit authorizations to the claim's vendor, they also have direct access into the authorization system and can verify the authorization that way also.

3. Deficiencies in encounter data reporting

Finding

Premier inadequately reported encounter data required by the TennCare Partners contract. Encounter data, a record of mental health and substance abuse services provided to enrollees, is necessary for evaluation of quality of care and access to TennCare Partners services. The following deficiencies were discovered for encounter data reporting:

- For 11 claims, a substitute code was incorrectly reported for the medical diagnosis codes indicated on the claims.

- For one claim, the reported outpatient service per the claim was not the same as the service entered into the claims processing system.

- For 13 claims, all listed diagnosis codes were not reported as encounter data. The list of required encounter data elements includes up to five diagnosis codes.

- For 7 claims, an abbreviated number for the diagnosis code was reported as encounter data instead of diagnosis code indicated on claim. The abbreviated diagnosis code does not fully report the specific mental health or substance abuse diagnosis.

- Premier could not provide encounter data for 5 claims.

- Copies of 3 of the 26 claims provided by Options were illegible. A copy of one of the 54 claims provided by GSHS was illegible. We were not able to ascertain compliance with contract reporting requirements.

Section 3.12.5 of the TennCare Partners contract with Premier states,

> The CONTRACTOR shall furnish to TennCare information regarding individual encounters (individual units of service provided to Participants). Encounter information will be submitted for all covered services as listed in Section 2.6. This information shall be reported in a standardized format as specified by TDMHMR and transmitted electronically to TennCare on a basis specified by TDMHMR and the Bureau of TennCare. The minimum data elements required to be provided are identified in Attachment E.5 of the CONTRACT.

Recommendation

Premier should correctly report encounter data as specified in The TennCare Partners contract.

Management's Comment

We feel that with the new claims vendor the requirements for encounter data will be met.

4. Inaccurate annual and quarterly statement reporting

Finding

The following deficiencies in financial reporting were noted on the annual statement of Premier for the year ended December 31, 1997:

- Receivables of $207,775 were improperly included as an admitted asset on the annual statement. Assets with uncertain collectibility should not be admitted, according to statutory accounting principles.

- Accounts payable for pharmacy expenses and premium tax payables were understated by $159,849 and $69,173, respectively. The liabilities were corrected based on actual payments.

- Capitations fee payments from TennCare of $1,560,794 were incorrectly recorded as deferred revenue.

- The settlement receivable with the State of Tennessee for payments to the regional mental health institutes was ultimately $396,679 greater than reported.

The following deficiencies in financial reporting were noted on the quarterly statement for the period January 1 through June 30, 1998:

- Receivables of $592,256 were improperly included as an admitted asset on the annual statement. Receivables that exceed 90 days or that have uncertain collectibility should not be admitted, according to statutory accounting principles.

- Accounts payable for pharmacy expenses and premium tax payables were understated by $981,647 and $50,261, respectively. The liabilities were corrected based on actual payments.

- Capitations fee payments from TennCare were overstated $715,138.

- Interest receivable was understated $2,556.

- The settlement payable with the Community Mental Health Centers (CMHCs) ultimately was $2,328,721 less than estimated.

- Because of deficiencies of case management reporting by the CMHCs, the Bureau of TennCare permanently retained the 10% withholds from capitation payments for January and February 1998, totaling $3,204,831. In August and September 1998, Premier recouped this amount from the capitation payments it makes to the CMHCs. The effect of these events was to decrease premiums earned and CMHC capitation expense by $3,204,831.

Section 3.13.1 of the TennCare Partners contract with Premier states that

> The CONTRACTOR shall establish and maintain an accounting system in accordance with generally accepted accounting principles. The accounting system shall maintain records pertaining to the tasks defined in the CONTRACT and any other costs and expenditures made under the CONTRACT.

As a result of the inaccurate annual and quarterly statement reporting, equity is understated $1,520,677 as of December 31, 1997, and overstated $8,656 as of June 30, 1998. The Department of Commerce and Insurance and the Department of Mental Health and Mental Retardation cannot adequately assess the effectiveness of the TennCare Partners Program because of the inaccuracies in annual and quarterly statement reporting.

Recommendation

Premier should accurately file the annual and quarterly statements. Receivables which exceed 90 days or that have uncertain collectibility should not be included as admitted assets. Premium taxes should be reported by applying the appropriate rate to premium revenue. Interest income should reflect interest earned as of the filing period of the statement. Revenue should be reported in the period it is earned.

Management's Comment

Management did not respond to this finding.

5. Incomplete payment calculations to community mental health centers

Finding

Premier did not apply all of the compensation terms of their contracts with CMHCs. Each CMHC is entitled to 75% of monthly calculated inpatient savings as a result of the reduction in expenses for inpatient treatment, group home, and 24-hour residential treatment services. The savings is to be calculated and paid to the CMHC at the same time as the monthly case rate calculation and payment. Premier has established a liability for this calculation, but no payments have been made to the CMHCs for this contracted calculation.

Premier began correctly applying all terms of the monthly case rate calculation in December 1997. By November 1998, Premier had reached a settlement with most CMHCs for the monthly case rate calculation for the period July 1, 1997, to November 30, 1997.

Recommendation

Premier should apply all of the compensation terms of their contracts with the CMHCs. An inpatient savings should be computed on a monthly basis. If an inpatient savings exists, the CMHC should be paid at the same time as the monthly case rate payment.

Management's Comment

Management did not respond to this finding.

6. Provider contract language deficiencies

Finding

Premier did not comply with the Bureau of TennCare's requirements for provider agreements. The provider agreements did not contain all requirements specified in Section 3.9 of the contract between TennCare and Premier.

Language describing the following requirements is excluded or deficient in contracts between Premier and its medical providers:

- Specify a term of no less than one (1) year and cancellation clauses must not be less than sixty (60) days.

- The contract provided the page for the name and address of the official payee to whom payment shall be made, but the page is left blank.

- Specify both the CONTRACTOR and the provider agree to recognize and abide by all state and federal laws, regulations, and guidelines applicable to the behavioral health organization plan.

- Such change shall only be valid when reduced to writing, duly signed, and attached to the original agreement.

- Specify that such records shall be at no expense to Tennessee Department of Mental Health and Mental Retardation (TDMHMR).

- The arbitration procedure proposed by the CONTRACTOR shall be submitted to the TennCare Division of Tennessee Department of Commerce and Insurance (TDCI) for review and approval within thirty (30) calendar days of execution of this CONTRACT. If the CONTRACTOR has an existing alternative arbitration procedure, the CONTRACTOR may submit the existing arbitration procedure to the TennCare Division of TDCI for review and approval. The TennCare Division of TDCI shall approve or deny the proposed arbitration procedure within thirty (30) calendar days after the receipt of the proposal from the CONTRACTOR. Any subsequent modification to the arbitration procedure by the CONTRACTOR must also be reviewed and approved by the TennCare division of TDCI. Said modification shall be sent by Certified Mail-Return Receipt Requested to the TennCare Division of TDCI which shall approve or deny the proposed modification within thirty (30) calendar days after the receipt of said modification from The CONTRACTOR.

- Specify that the provider submit to the CONTRACTOR the necessary information so that the CONTRACTOR can determine the average unit costs pursuant to Section 3.12.7.4.

- Specify the provider must comply with claims processing requirements as referenced in Section 3.13.2.

- Specify the contract is not exclusive with respect to any service or geographic area.

- No agreement executed between the CONTRACTOR and a provider shall require the provider to assume financial risk for the provision of services which are not directly or indirectly furnished by that provider to a participant in the TennCare Partners Program. The term "indirectly" means that the provider retains ultimate management and control over the services furnished to participants in the TennCare Partners Program. The CONTRACTOR shall submit to the State for approval amendments which bring provider contracts into compliance with this section by June 24, 1997, and shall execute all such provider contract amendments within thirty (30) days of State approval. The CONTRACTOR may request the TennCare Division of TDCI to provide, in advance, a written opinion whether a proposed contract provision is in compliance with this section, and the TennCare Division of TDCI must respond to any such request within thirty (30) calendar days after receipt of the request by the TennCare Division of TDCI. TDMHMR, in addition to any and all remedies set forth in this CONTRACT, may also commence an action against the CONTRACTOR in accordance with Section 6.11 of this CONTRACT to recover from the CONTRACTOR any losses incurred by a provider as a result of the CONTRACTOR's breach of this section. Any amounts recovered by TDMHMR which are for losses incurred by a provider as a result of the CONTRACTOR's breach of this section shall be returned without interest to the provider.

Recommendation

Premier should comply with the TennCare Bureau's requirements regarding provider agreements. The provider agreements should contain all items specified in Section 3.9 of the TennCare Partners contract.

Management's Comment

We are currently in the process of recontracting with providers. All contract language has been approved by the State.